REMARKS BY REPRESENTATIVE HENRY A. WAXMAN
BEFORE THE ALLIANCE FOR HEALTH REFORM
PRIMARY CARE CONFERENCE
July 15, 1993

Good afternoon. I'm delighted to be here today to participate in this important and timely conference, and to pay tribute to the work of the Alliance for Health Reform and its founder, Senator Jay Rockefeller.

As we consider the many challenges of reforming our health care financing and delivery system, few problems are as important and urgent as meeting the primary care needs of the American people. With support from the W.K. Kellogg Foundation and a distinguished study panel led by Dr. Reed Tuckson, the Alliance has produced a thoughtful and practical policy agenda for increasing the availability of primary care practitioners.

I know how hard this task can be. As many of you know, I have been associated with a number of initiatives to change the incentives that influence the education of health professionals. The Alliance's report documents many of these efforts and concludes -- accurately -- that we have been unable to stem the tide of specialization that has left the United States far behind other developed nations in meeting the basic primary and preventive care needs of our people.

I am pleased that the Alliance has focused attention on the need to develop a coherent workforce policy and that it is being considered as an essential component of health care reform. Senator Rockefeller and I have been collaborating on legislation building on the recommendations of the Alliance's report -- I want to say more about that in a minute.

We believe that health reform will be a hollow promise for many if we do not assure that health professionals are in place to deliver needed primary and preventive services.

The Chance for Reform

Let me say just a word about the opportunity for health reform and why we must seize this chance to address some long-standing problems that many believed were intractable. Few would argue that our health system is in crisis. The growing number of uninsured, the spiraling costs of care, and the mis-allocation of our capital and human resources -- together have produced deep public dissatisfaction.

More harmful has been the toll in human suffering that results from a health system that under-values primary and preventive services.

Now we have the convergence of two forces that, in my view, make health reform not only necessary, but possible. First, we have a growing public recognition -- aided importantly by the work of the Alliance for Health Reform -- that we are on a self-destructive course -- a course that threatens not only the poor but all Americans. This awareness offers the opportunity to gain broad support for comprehensive health reform.

Second, we have a President and a First Lady who understand the problems we face, and who are committed to provide the kind of sustained leadership that will be required to reach consensus on a reform plan.

I would be less than candid not to acknowledge that the President's plan will face tough going in Congress. We know that all good ideas have their naysayers. There are some who are likely to vote against any plan that requires universal coverage, or one that deals effectively with the growth in health costs.

Others will recommend incremental insurance reforms or voluntary approaches that rely on taxing health benefits. Others will argue that we cannot afford universal coverage. And, still others will urge delay or further study -- a course which can only lead to higher costs and greater disparities in the health of our people.

I think they are all wrong.

Our most costly and damaging option -- both in terms of dollars and the health of the American people -- is to do nothing. The prospect of continuing 12 to 15 percent a year increases in health costs and the impact of this inflation on our standard of living is reason enough to put aside our differences and work for health reform.

If we can stick to the fundamental principles of universal and uniform coverage, progressive financing, consumer choice, and cost containment, the American people will embrace reform.

But, we must take care, however, not to permit the naysayers -- the defenders of the status quo -- the opportunity to pick the proposal to pieces.

The Need for a Primary Care Workforce Policy

As I noted a moment ago, increasing the number of primary care professionals is an integral part of health reform. Over the years our incremental efforts to address the shortage of primary care practitioners have produced uneven results.

While efforts to increase enrollments in medical schools in the 60s and 70s succeeded, that legacy has been a substantial over-supply of specialists. As a long-time advocate of the National Health Service Corps, I know its important role in increasing opportunities for disadvantaged students and providing services in under-served areas. However, we have not funded it adequately. Today there are thousands of medically underserved communities without access to basic primary care services. Moreover, there were over 2000 applications for fewer than 400 Corps scholarships last year.

For the National Health Service Corps to reach full strength and serve those regions where health professions shortages are most severe, funding for the Corps must be dramatically raised -- from under $100 million today to over $1 billion by the turn of the century. We must take advantage of the idealism of our nation's young people and encourage Corps participation as an important part of President Clinton's call for national service.

But full funding of the Corps is only a partial response to serious shortages of primary care providers. In what I believe to be a very significant attempt to encourage more medical students to enter primary care practice, Senator Rockefeller and I in 1989 strongly supported the adoption of a Medicare Fee Schedule based on physician resource costs rather than historical charging patterns. This Medicare RB-RVS policy increases payments for primary care and patient management services, while at the same time reducing excessively high payments for surgical and diagnostic procedures.

As many of you know, it has been hard to protect the Medicare Fee Schedule from the Bush Administration's attempt to subvert the intent of this policy with questionable volume off-sets, while fending off other efforts to use it for achieving further deficit reduction. I believe we risk losing the trust of the physician community if we do not make a good faith effort to stick to the terms of our 1989 agreement. We must ensure that primary care services are compensated fairly.

In the long run, I believe that increasing the value attached to primary care services, and improving the practice environment for primary care physicians will have a powerful impact on the specialty choices of medical students.

But these changes will not be enough. The Alliance's Report identifies a number of additional, critical steps we must take. Medical schools need to increase their enrollment of minority students, and to modify their curricula to emphasize primary care. The Report recognizes that the number of graduate medical education training slots for specialties should be reduced and slots for primary care increased. Finally, the Report calls for enhancements to primary care research and increases in the supply of nurse practitioners, nurse mid-wives, physician assistants, and other primary care practitioners.

In sum, we need a comprehensive and coordinated strategy to reach our health workforce objectives. We have a chance to create a health workforce policy that serves the needs of all Americans. The Alliance has made an important contribution to this effort, and it has certainly influenced the legislation that Senator Rockefeller and I will be introducing shortly.

The Waxman-Rockefeller Primary Care Workforce Act

The bill we are introducing next week will highlight those key workforce policies that we believe are critical to the success of a reform plan. The bill draws not only from the Report of the Alliance, but also recommendations from the Administration, the Physician Payment Review Commission, the Council on Graduate Medical Education, and a number of other thoughtful reports that have addressed these issues.

The bill establishes a national policy respecting the number and type of graduate medical education programs that will be eligible for federal support. While the bill specifically revises Medicare payment policies for graduate medical education, I want to make it clear that -- in the context of health reform legislation -- it will be necessary to ensure that all payers share in the cost of educating health professionals.

The bill requires a 50-50 mix in the number of primary care and specialty training programs, and, after a transition period, establishes an outside limit on the total number of accredited residency positions that can receive Medicare funding.